City of Tucson
2020-21 Plan Year
Medical Opt Out Incentive Program

Complete your information below AND page 2 of this form.

a. I understand that I have been offered the opportunity to enroll myself and my eligible dependents in my employer-sponsored medical plan(s) and that the medical plan(s) are considered to be minimum essential coverage (MEC) in accordance with the Affordable Care Act (Health Reform).

b. I understand that without medical plan coverage I (and my dependents, if any) could have a financial penalty applied when my/our personal income taxes are filed with the IRS. (I understand I can learn more about the financial penalty, called the Individual Mandate penalty, at this government website: https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/).

c. I understand that without an IRS-approved mid-year life change event (a Special Enrollment event, also known as a "qualifying life event") that is recognized by the City of Tucson, **if I decline coverage now**, I will not be permitted the opportunity to enroll myself or my eligible dependents in my employer's medical plan option(s) again until my employer's next annual open enrollment time (if I am benefits-eligible at that time).

d. I understand that there is additional taxable compensation of $36.92 per pay period provided to me if I decline coverage *and* provide acceptable proof of non-City of Tucson medical insurance. I understand that **I am only able to receive this additional compensation for declining coverage IF I, and all members of my expected tax family (tax family refers to dependents on the employee's tax return), have or will have for the plan year (July 1 – June 30) other minimum essential coverage through** another employer's group medical plan, Medicare, Medicaid (called AHCCCS in Arizona), Tricare, Veterans Affairs (VA) or Indian Health Services (IHS) medical plan coverage.

- I understand that I am not eligible to receive this compensation if I or any member of my expected tax family (tax family refers to dependents on the employee's personal tax return) is enrolled in individual market coverage, whether obtained through a Marketplace established under Health Reform, or outside of the Marketplaces established under Health Reform.
- I understand that my employer will not make any payment to me if my employer knows or has reason to know that I or any member of my expected tax family does not have or will not have the required alternative coverage.
- I understand that I will be required to attest to this alternative coverage ***each plan year*** that I decline coverage under my employer's group medical plan.
- I understand that I am not eligible to receive this incentive if I am covered for medical insurance through a City of Tucson medical insurance plan (example: as the dependent of another City of Tucson employee or retiree).
- I understand that payments of the $36.92 biweekly will not be made retroactively if the Benefits Office receives my form and documentation after my insurance start date; however, I would be eligible to receive payments on a prospective basis once the Benefits Office receives my form and documentation.

Signature:_____ **Employee #:**_____

Printed Name (Last, First, MI):_____ Date of Birth: _____

Address: _____

City, State Zip: _____ E-mail: _____

Phone: *(Home)*_____ *(Work)*_____ *(Cell)* _____

***** UPLOAD PICTURE(S) OR SCAN(S) OF YOUR FORM AND SUPPORTING DOCUMENTATION to the City's enrollment system via the "enroll" link at www.tucsonaz.gov/insurance *****

Completion of the following chart is REQUIRED TO RECEIVE INCENTIVE PAYMENT:

Name of Tax Family Member *(please print)* *"**Tax Family**" includes all dependents on the employee's personal tax return.*	**Relationship to Employee**	**Print Name of Other Alternative Minimum Essential Coverage, Plan Sponsor, and Contact Information**
	☒Employee	☐ Employer Plan ☐ Medicare ☐ IHS (Indian Health) ☐ Medicaid/AHCCCS ☐ Tricare ☐ VA (Vet Admin) **Name of Other Coverage:** **Plan Sponsor:** **Contact Information:**
	☐ Spouse ☐ Child ☐ Other	☐ Employer Plan ☐ Medicare ☐ IHS (Indian Health) ☐ Medicaid/AHCCCS ☐ Tricare ☐ VA (Vet Admin) **Name of Other Coverage:** **Plan Sponsor:** **Contact Information:**
	☐ Spouse ☐ Child ☐ Other	☐ Employer Plan ☐ Medicare ☐ IHS (Indian Health) ☐ Medicaid/AHCCCS ☐ Tricare ☐ VA (Vet Admin) **Name of Other Coverage:** **Plan Sponsor:** **Contact Information:**
	☐ Spouse ☐ Child ☐ Other	☐ Employer Plan ☐ Medicare ☐ IHS (Indian Health) ☐ Medicaid/AHCCCS ☐ Tricare ☐ VA (Vet Admin) **Name of Other Coverage:** **Plan Sponsor:** **Contact Information:**
	☐ Spouse ☐ Child ☐ Other	☐ Employer Plan ☐ Medicare ☐ IHS (Indian Health) ☐ Medicaid/AHCCCS ☐ Tricare ☐ VA (Vet Admin) **Name of Other Coverage:** **Plan Sponsor:** **Contact Information:**

Use additional forms for any additional tax family members.

- ✓ I certify that the above is a complete list of each member of my expected tax family (dependents on my personal tax return), and that I and each member of my expected tax family have (or will have) this other alternative coverage for the plan year (July 1 – June 30).
- ✓ **I am providing proof of my own other medical insurance with this form*.** I understand that my employer may, in the future, also require proof of alternative coverage for my tax family members.
- ✓ I agree to notify the City of Tucson Benefits Office (benefitquestions@tucsonaz.gov, 520-791-4597) promptly if I or any member of my expected tax family loses this alternative coverage, and I understand that incentive payments will be stopped at that time.

My signature below means that the above information I have provided is true and correct, and I have read and understand all of the statements on pages 1 and 2 of this form.

Signature:____________________________________ Employee#:________________

Printed Name (Last, First, MI):__________________________Date:________________, 20___

* *Your proof must include your name as it appears in the City of Tucson payroll system and must show that your medical coverage is currently in effect. Examples include a dated printout from your online medical insurance record or employer's enrollment system, a letter from the employer sponsoring the medical plan or insurance company, or a copy of your ID card if it shows an effective date within the past 60 days.*

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